Print Reset Form

Instructions for Completion

Fill-In Instructions

INSURER'S NOTICE OF ISSUANCE OF POLICY

Michigan Department of Consumer & Industry Services
Bureau of Workers' & Unemployment Compensation
P.O. Box 30016, Lansing, Michigan 48909

Authority: Workers' Disability Compensation Act 418.625(1), R408.41. Completion of this form is mandatory.

INSTRUCTIONS: SEE REVERSE SIDE

A separate form 400 is required for each legal entity insured under a policy

1. Employer Federal I.D. Number **Click Here to Start**	2. Name of Business
3. Parent Co. Federal I.D. Number	4. Owner of Business (if applicable)

5. Mailing Address (Street Number and Name)	City	State	ZIP Code

6. Type of Organization

☐ a. Corporation ☐ c. Individual ☐ e. Joint Venture
☐ b. Partnership ☐ d. Public Employer ☐ f. Limited Liability Company/Other

7. NAIC Carrier I.D. Number (9 digits)	8. Zip Code of Issuing Office	9. Name of Insurance Company

10. Policy Number	11. Effective Date of Coverage

12. Annual Payroll in Dollars	13. Michigan Class Code	14. Number of Employees

Pursuant to the Workers' Disability Compensation Act, this is to certify that the above referenced employer has been issued a policy of insurance by the above carrier. This policy covers all the liability imposed upon the employer by the provisions of the Michigan Workers' Disability Compensation Act for all employees in any and all of the employer's businesses.

15. Authorized Signature	Date

16. Please list below additional names and/or addresses for the Federal I.D. Number listed in item #1. (A separate form 400 is required for each legal entity insured under a policy)

Name of Business			Name of Business		
Address (Street Number and Name)			Address (Street Number and Name)		
City	State	ZIP Code	City	State	ZIP Code
Name of Business			Name of Business		
Address (Street Number and Name)			Address (Street Number and Name)		
City	State	ZIP Code	City	State	ZIP Code

Purpose of Form BWC-400:
To notify the Michigan Bureau of Workers' Disability Compensation that a policy of workers' compensation insurance has been issued to an employer.

When Required:
Must be filed with the Bureau within 30 days after the effective date of coverage.

General Guidelines for Completing Form BWC-400:
a. A Form BWC-400 is a continuous filing. A Form BWC-401, Notice of Termination of Liability, only needs to be filed when terminating all coverage for an employer.
b. If a new division (assumed name or DBA) is to be added to an existing policy, a Form BWC-403, Insurer's Notice of Name or Address Change, must be filed which shows the additional business name operating under the same Federal I.D. Number. Do not file a Form BWC-401 in this situation.
c. If there are certain locations of the employer that change address, a Form BWC-403 must be completed. Form BWC-400s and Form BWC-401s **should not** be filed for address changes. If the main address of the employer changes, that change must be submitted on a Form BWC-403.
d. Separate Form BWC-400s must be filed for each business that has a different Federal I.D. Number.

INSTRUCTIONS FOR COMPLETION

Item #1 — Employer Federal I.D. Number (9 digits)
Enter employer's Federal Identification Number. This is a nine digit number. If an individual (sole proprietor) does not have a Federal I.D. Number, the Social Security Number of the individual will be accepted. A Federal I.D. Number or a Social Security Number is **required** on all Form BWC-400 filings.

Item #2 — Name of Business
Enter complete names of all of the businesses including all assumed names (even if the names are not registered) and division names that operate under the **same** Federal I.D. Number listed in Item #1.
Additional assumed names or division names operating under the same Federal I.D. Number should be listed in Item #16 on the lower portion of the form. If there are more than four additional names, another Form BWC-400 must be completed. Do not place additional business or division names on the back of the Form BWC-400.

Item #3 — Parent Co. Federal I.D. Number
Enter Federal I.D. Number of parent company when applicable.

Item #4 — Owner of Business (if applicable)
List the complete name of the corporation, partnership, individual, public employer, joint venture, or limited liability company which owns the business. If Item #2 is identical to Item #4, leave Item #4 blank.

Item #5 — Mailing Address
The mailing address of the business, including city, state, and ZIP code (5+4) must be identified. Street address of the business should be shown in Item #16. Additional Michigan addresses should be placed in Item #16. If there are more than four additional addresses, another Form BWC-400 must be completed.

Item #6 — Type of Organization
State whether the employer is a corporation, partnership, individual, public employer, joint venture, or limited liability company/other.

Item #7 — NAIC Carrier I.D. Number (9 digits)
National Association of Insurance Commissioner's (NAIC) I.D. Number (5 digits) followed by the group number (4 digits) of the insurance company.

Item #8 — Zip Code of Issuing Office
Show the complete ZIP code for the insurance carrier office issuing this form. A complete list of the ZIP codes for all carrier issuing offices must be on file with the Bureau. This ZIP code will be used on all correspondence sent by the Bureau to the designated contact person for each carrier.

Item #9 —Name of Insurance Company
The full name of the insurance company.

Item #10 — Policy Number
Enter complete policy number. Maximum 20 digits.

Item #11 — Effective Date of Coverage
Enter the date the policy is effective. Numeric (month/day/year).

Item #12 — Annual Payroll in Dollars
Anticipated or actual annual payroll in dollars for the employer.

Item #13 — Michigan Class Code
Use class code found in the Michigan Workers' Compensation Statistical Plan which shows the highest amount of payroll (other than standard exceptions).

Item #14 — Number of Employees
Enter the number of employees for employer who are employed in Michigan.

Item #15 — Authorized Signature
Must have an original signature in black or blue ink. Typed signatures are not acceptable. Include the date the form was signed.

Item #16 — Additional Names and/or Addresses of the Business
See Item #2 and Item #5 for instructions.

Go back to Page 1

Form #	**BWC-400**	**Form Name:**	**Insurer's Notice of Issuance of Policy**

When Required:

Each insurer, when issuing an insurance policy for an employer covering workers' compensation in Michigan, shall file the Notice of Issuance of Policy BWC-400 within 30 days of the effective date of coverage.

Required Fields:

Forms submitted without the following required fields completed will either be returned or a letter will be generated asking for this information:

1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15

Instructions:

Completing the Form:

- ✔ Select the hand tool from the Acrobat toolbar menu. You can use the hand tool to move the page around so that you can view all areas.
- ✔ Position the hand pointer inside a form field and click. The I-beam pointer allows you to type text.
- ✔ To complete the "red boxes," using your mouse, position the cursor over the applicable box until the pointing finger icon appears and click.
- ✔ Press Tab to accept the field change and go to the next field, or
  Press Shift + Tab to accept the field change and go to the previous field.
- ✔ Use your mouse to select an area of the form that is not inside a form field before printing your form.
- ✔ To print the form, be sure to use the printer button on the Acrobat toolbar menu instead of your web browser's print function. You may need to select the “Print as image” option in the print dialog box to print the completed form.

NOTE: Please complete all date fields with the **MM/DD/YYYY** format.

How to Submit This Form:

- ✔ Print the completed form
- ✔ Sign the form
- ✔ Make 1 copy for your records
- ✔ Send the original of the signed Form 400 to:

Bureau of Workers’ Disability Compensation
P O Box 30016
Lansing MI 48909